

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/15/2011  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155176 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>02/09/2011 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GLENBROOK REHABILITATION & SKILLED NURSING CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3811 PARNELL AVE<br>FORT WAYNE, IN 46805                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETION<br>DATE |                                                 |
| K 000                                                                                 | <p>INITIAL COMMENTS</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/09/11</p> <p>Facility Number: 000092<br/>Provider Number: 155176<br/>AIM Number: 100266090</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Glenbrook Rehabilitation and Skilled Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 90 and had a census of 72 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/14/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as</p> | K 000                                                               | <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review in lieu of a post survey review on or after April 27, 2011. More time is being requested for completion of tag K 021.</p> |                            |                                                 |

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FEB 28 2011

LONG TERM CARE DIVISION  
INDIANA STATE DEPARTMENT OF HEALTH

APPROVED

3/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 000                                                                                 | Continued From page 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | K 000                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                 |
| K 021<br>SS=E                                                                         | <p>evidenced by the following:</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed.</p> <p>19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 roll down doors at the openings in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect all residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 02/09/11 at 1:40 p.m., observation revealed the dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall</p> | K 021                                                               | <p><b>K 021</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>No residents were identified as being affected.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>The rolls down doors identified are the only ones installed in the facility. These doors are only up during meal times.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Outside contractors have been contacted to rewire the existing the roll down doors to the fire alarm system so that they will automatically close upon activation of the fire alarm system. This process includes replacing the existing doors and wiring them into the system. This will take up to 6 weeks to complete.</p> <p>Maintenance Director and/or designee in serviced all staff, by 2-24-2011, about manually pulling doors down immediately when fire alarm system is activated.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient</b></p> |  |                                                 |

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| K 021                                                                                            | Continued From page 2<br>around the dining room is therefore, considered to be the corridor wall. There were two pass through openings in the corridor wall between the dining room and the kitchen. Each opening was protected with a rolling fiberglass door that could only be released manually. This was acknowledged by the Maintenance Supervisor at the time of observation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | K 021                                                                      | <b>practice will not recur, i.e., what quality assurance program will be put in place.</b><br>Maintenance Director and/or designee will monitor doors during monthly fire drills. Data will be submitted to CQI Committee monthly for review and follow up.<br><br><b>Date of Compliance: April 27, 2011</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
| K 046<br>SS=C                                                                                    | 3.1-19(b)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br><br>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 19 of 21 emergency lights were tested annually for at least a 1½ hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on an observation with the Maintenance Supervisor on 02/09/11 from 12:25 p.m. to 2:00 | K 046                                                                      | <b>K 046</b><br><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b><br>No residents were identified as being affected by alleged deficient practice.<br><br><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b><br>All battery operated emergency lights were tested for 90 minutes on 2-10-11.<br><br><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b><br>Maintenance Director and/or designee will monitor the annual testing of the lights.<br><br><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</b> |                            |                                                        |

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| K 046                                                                                            | Continued From page 3<br>p.m., 21 battery operated emergency lights were<br>observed throughout the facility. Based on an<br>interview with the Maintenance Supervisor at the<br>time of observation, the only emergency lights<br>that received an annual test were the two located<br>in the service hall.<br><br>3.1-19(b) | K 046                                                                      | <b>assurance program will be put into<br/>place</b><br>Maintenance Director and/or designee will<br>monitor the testing of all battery operated<br>emergency lights monthly. Information<br>will be submitted and reviewed with CQI<br>committee quarterly.<br><br><b>Date of compliance: February 10, 2011</b> |                            |                                                        |